



# CONNECTICUT ACADEMY of GENERAL DENTISTRY

## 2026 AGD Membership Application

Join online at agd.org, or call us at 888.243.3368 or 312.440.4300.

### MEMBER INFORMATION

First name \_\_\_\_\_ MI \_\_\_\_\_ Last name \_\_\_\_\_ Designation (e.g. DDS, DMD, BDS) \_\_\_\_\_ Primary Email address \_\_\_\_\_

Do you currently hold a valid U.S./Canadian dental license?  No  Yes: \_\_\_\_\_  
License number \_\_\_\_\_ State/province \_\_\_\_\_ Date renewed (mm/yyyy) \_\_\_\_\_

Type of membership: (Check one.)  Active general dentist  Associate (dental specialist)  Resident  Dental student  Affiliate

If you are not in general practice, please indicate your specialty: \_\_\_\_\_

Current dental practice environment: (Check one.)  Solo  Associateship  Group practice  Hospital  Resident  Corporate

Other \_\_\_\_\_  Full-Time Faculty \_\_\_\_\_  Federal Services \_\_\_\_\_  
Please indicate institution \_\_\_\_\_ Please indicate branch \_\_\_\_\_

### CONTACT INFORMATION

Preferred billing/mailling address:  Business  Home

Your AGD constituent is determined by your business address, unless one is not available.

Business address \_\_\_\_\_ City \_\_\_\_\_ State/province \_\_\_\_\_ ZIP/postal code \_\_\_\_\_

Name of business (if applicable) \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Home address \_\_\_\_\_ City \_\_\_\_\_ State/province \_\_\_\_\_ ZIP/postal code \_\_\_\_\_

Phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Alternate email \_\_\_\_\_ Date of Birth \_\_\_\_\_

### EDUCATIONAL INFORMATION

Are you a graduate of an accredited\* U.S./Canadian dental school?  Yes  No  Currently enrolled

Dental school \_\_\_\_\_ State/province \_\_\_\_\_ Country \_\_\_\_\_ Date of graduation (mm/yyyy) \_\_\_\_\_

Are you a graduate of (or resident in) an accredited\*\* U.S. or Canadian postdoctoral program?  Yes  No  Currently enrolled Type:  AEGD  GPR  Other

\*Official accreditation is given by CODA in the U.S. and CDAC for all Canadian provinces. \*\*Accredited dental residencies qualify for the resident membership rate. Official proof of enrollment must be provided to AGD.

Postdoctoral institution \_\_\_\_\_ State/province \_\_\_\_\_ Country \_\_\_\_\_ Start date (mm/dd/yyyy) \_\_\_\_\_ End date (mm/dd/yyyy) \_\_\_\_\_

### OPTIONAL INFORMATION

Gender:  Male  Female  Prefer not to disclose  Not listed  
Ethnicity:  American Indian  Asian  African-American  Hispanic  Caucasian  Other

I am interested in participating in the AGD Mentor Match Program as a:  Mentor  Mentee

#### 2026 AGD Dues

- Please check membership type applying for:
- Active General Dentistry ..... \$496
  - Associate (Specialist) ..... \$496
  - Affiliate..... \$248
  - 2025 Graduate ..... \$99
  - 2024 Graduate ..... \$198
  - 2023 Graduate ..... \$298
  - 2022 Graduate ..... \$397
  - Student/Resident ..... \$22

#### 2026 Connecticut AGD Constituent Dues

- Active General Dentist.....\$25
- Associate.....\$25
- Affiliate.....\$0
- 2025 Graduate .....\$25
- 2024 Graduate .....\$25
- 2023 Graduate .....\$25
- 2022 Graduate .....\$25
- Student/Resident.....\$0

1. AGD Dues: ..... \$ \_\_\_\_\_  
Upgrade to Premium Plus Membership\* (Add \$199 USD) ..... \$ \_\_\_\_\_
2. AGD Constituent Dues: ..... \$ \_\_\_\_\_
3. AGD Component Dues:..... \$ \_\_\_\_\_
- Total Amount Enclosed:**..... \$ \_\_\_\_\_

Individuals joining July 1 to Sept. 30, 2026, pay half the annual headquarters membership dues (does not apply to student, resident, first-year graduate, or affiliate members). Individuals joining Oct. 1 to Dec. 31, 2025, enjoy membership through the end of 2026. Paid dues will be applied to the upcoming year.

Student and resident members are not eligible for Premium Plus Membership. Head to [agd.org/membership](http://agd.org/membership) to review a full listing of membership benefits.

† Please note that credit card payments are subject to an additional 3% processing fee not reflected in the dues total shown.

Per the U.S. Revenue Reconciliation Act of 1993, 6.36 percent of membership dues payment is allocable to the AGD's lobbying activities and is not deductible as a business expense. Please consult with your financial adviser for detailed information.

Dues rates effective through September 30, 2026. Contact the AGD or visit [agd.org](http://agd.org) for updated rates.

I hereby certify that all of the above information is correct, and that by signing this application, I agree to all terms of membership including completion of 75 hours of continuing education every three years for active general dentist and associate members.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Note: Check payment is required with hard copy applications. To pay with credit card,† please apply online at [agd.org/membership](http://agd.org/membership). If you have any questions, please contact our Membership Services Center at 888.243.3368.**

**Please sign this application and submit payment to:**  
ACADEMY OF GENERAL DENTISTRY  
PO BOX 4451  
CAROL STREAM, IL 60197-4451